MOTION FILED

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No. 09-438

In The
Supreme Court of the United States

PROVIDENCE HOSPITAL AND
MEDICAL CENTERS, INC.,
Petitioner,

v.

JOHNELLA RICHMOND MOSES, Personal Representative
of the Estate of MARIE MOSES-IRONS, Deceased,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

MOTION TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI AND BRIEF OF *AMICUS CURIAE* THE MICHIGAN HEALTH & HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONER

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November 12, 2009

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MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

Pursuant to Rule 37.2(d) of the Rules of the Supreme Court, the Michigan Health & Hospital Association (MHA) moves this Court for leave to file the accompanying Brief *Amicus Curiae* in support of the Petition for Writ of Certiorari submitted by Petitioner, Providence Hospital and Medical Centers, Inc. Respondent has not granted consent, and this motion is therefore necessary.

The Michigan Health & Hospital Association is an association of hospitals, health systems, and other health care providers throughout Michigan that work together with patients, communities, and providers to improve health care for all Michigan citizens by addressing current issues that impact the ability of its members to deliver care. MHA membership includes all of the state's 145 nonprofit community hospitals, from the largest urban teaching and trauma centers to remote federally designated Critical Access Hospitals that have 25 beds or fewer and serve Michigan's most rural communities.

The doors of Michigan's nonprofit hospitals are open to all, regardless of medical condition or ability to pay for care. In 2007, Michigan's nonprofit hospitals provided $2.6 billion in community benefit, inclusive of free services, health education, outreach, charity care, unpaid care, and state and federal underfunding. Recent economic strains have greatly increased the number of uninsured and underinsured patients seeking care in Michigan's community hospitals, while at the same time chronic underfunding and

underpayment for services weakens the ability of hospitals to continue to serve as the health care safety net for all Michigan's residents. Despite these challenges, the Michigan Health & Hospital Association and Michigan's community hospitals are committed to preserving this important mission.

Congress enacted the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), in 1986 to provide care to individuals who come to the emergency department, irrespective of coverage by Medicare, ability to pay, length of stay, or medical standards of practice. EMTALA was passed in response to growing concern over reports that hospital emergency rooms were refusing to treat patients with emergency conditions if those patients did not have medical insurance. See *Bryan v. Rectors & Visitors of the Univ of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), *quoting* H.R. Rep. No. 241, 99th Cong., 1st sess., part 1 at 27 (1985).

Moreover, the rights and obligations established by EMTALA are fully consistent with the mission of the MHA and Michigan's community hospitals—that is, to provide emergency medical care to all based upon medical need, regardless of ability to pay. The burden borne by these medical providers, however, is substantial, and that burden, as shown by discussions within the current national health care debate, is ever-increasing.

The decision of the Sixth Circuit in this case has expanded the responsibilities borne by health care providers under EMTALA beyond the emergency room to now include those individuals who proceed to good faith admissions for inpatient care and treatment.

This represents a substantial expansion of EMTALA obligations, and potential liabilities for EMTALA violations, beyond the Congressional intent to avoid "patient-dumping" at the emergency room. This expansion of EMTALA obligation by the Sixth Circuit is contrary to the Fourth and Ninth Circuits' readings of the statute. It is contrary to the interpretive rules promulgated by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services. Those Circuits and the regulatory agency have all held that EMTALA's stabilization requirement does not apply once an individual who has come to the emergency department has been admitted, in good faith, to the hospital as an inpatient. The Sixth Circuit, by virtue of this case, stands alone in its contrary interpretation of the EMTALA statute. Consequently, Michigan's hospitals have a substantially greater obligation under EMTALA than do health care providers within the other Circuits. Indeed, in all of the Circuits outside of the Sixth, health care providers follow the CMS regulation, which is consistent with the decisions in the Fourth and Ninth Circuits. Only health care providers within the Sixth Circuit are bound by the expanded role of EMTALA as determined by the Court in this case.

When an individual without insurance or other financial means to pay for medical services is admitted, in good faith, for inpatient treatment, that individual will have other protections, aside from EMTALA, to ensure appropriate care and treatment. These other protections could, indeed, result in liability where a health care provider breaches these other duties. But EMTALA creates substantial additional potential penalties and liabilities for hospitals which are claimed to have violated the

requirements of the Act. In other words, this extension of EMTALA greatly expands potential liability and penalty, including potential exclusion from the Medicare program. 42 U.S.C. § 1395dd(d)(1).

Given the implications of this Sixth Circuit decision for the hospitals, health systems, and other health care providers in Michigan, the MHA has a truly significant interest in this case. The Petition filed by Providence Hospital and Medical Centers has great implication for the delivery of quality medical care to the public by all health care providers within the Sixth Circuit.

The MHA submits the attached Brief to explain, further, the importance of the question presented by this case for all of the MHA constituent members. This Court must resolve the conflict between this interpretation of EMTALA by the Sixth Circuit and the contrary interpretation of it by other Circuits and the Centers for Medicare and Medicaid Services through its promulgated rules.

For the above reasons, the Michigan Health & Hospital Association respectfully requests that this Motion for Leave to file the attached Brief, *Amicus Curiae*, be granted.

Respectfully submitted,

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QUESTIONS PRESENTED

The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), requires hospitals to "screen" any individual who "comes to the emergency department" and to "stabilize" an individual who is determined to have an "emergency medical condition." The Fourth and Ninth Circuits have held, and the Centers for Medicare and Medicaid Services ("CMS") by clarifying regulation in 2003 have directed, that the obligation to stabilize does not apply to an individual who is admitted to the hospital in good faith for inpatient care. The Sixth Circuit in this matter has created a direct conflict with other circuits, and has ruled CMS's regulation invalid, by holding that EMTALA's stabilization requirement extends indefinitely to those admitted to a hospital for inpatient care.

The questions presented are:

1. Whether EMTALA's requirement that any individual who comes to a hospital's emergency department with an emergency medical condition be screened and stabilized should be expanded to continue indefinitely, after the individual has been admitted as an inpatient to the hospital for care or treatment?

2. Whether the CMS's regulation clarifying that EMTALA is inapplicable to hospital inpatients, 42 C.F.R. § 489.24(d)(2)(i), is valid, and applies retroactively?

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INTEREST OF AMICUS CURIAE[1]

The Michigan Health & Hospital Association (MHA) is an association of hospitals, health systems, and other healthcare providers throughout Michigan that work together with patients, communities, and providers to improve health care for all Michigan citizens by addressing current issues that impact the ability of its members to deliver care. MHA membership includes all of the state's 145 nonprofit community hospitals, from the largest urban teaching and trauma centers to remote federally designated Critical Access Hospitals that have 25 beds or fewer and serve Michigan's most rural communities.

The doors of Michigan's nonprofit hospitals are open to all, regardless of medical condition or ability to pay for care. MHA's 2008 community benefits survey of Michigan's nonprofit hospitals revealed that, in 2007, those hospitals provided $2.6 billion in community benefit, inclusive of free services, health education, outreach, charity care, unpaid care, and state and federal underfunding. Recent economic

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[1] Counsel of record for Petitioner has waived the right to receive at least 10 days notice of amicus curiae's intention to file this brief and has consented to the filing of it. Counsel for Respondent has been notified of the intention to file and has consented to waiver of their right to receive at least 10 days notice. Petitioner's waiver of the notice period and consent, and Respondent's waiver of the notice period, are being filed concurrently with this motion and brief. Pursuant to Rule 37.6 of the Supreme Court of the United States, counsel for *amicus curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amicus*, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

strains have greatly increased the number of uninsured and underinsured patients seeking care in Michigan's community hospitals, while at the same time chronic underfunding and underpayment for services weakens the ability of hospitals to continue to serve as the health care safety net for all Michigan's residents. Despite these challenges, the Michigan Health & Hospital Association and Michigan's community hospitals are committed to preserving this important mission.

In 1986 Congress enacted the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), which obligates Medicare participating hospitals to provide care to individuals who come to the emergency department, irrespective of coverage by Medicare, ability to pay, length of stay, or medical standards of practice. While the purpose of EMTALA is entirely consistent with the mission of MHA and Michigan's community hospitals, EMTALA creates potential penalties and liabilities for hospitals in addition to those that might flow from the relationships between hospitals and patients independent of EMTALA. In other words, EMTALA creates another level of potential liability for Michigan's community hospitals.

The case now before the Court on the Petition by Providence Hospital interprets EMTALA in such a way that its obligations extend to patients who have been admitted, in good faith, for inpatient care and treatment, beyond the emergency room. This is an expansion of EMTALA responsibility for hospitals within the Sixth Circuit well beyond the responsibilities faced by hospitals in other Circuits. Concomitant with this expansion of EMTALA rights

and obligations for hospitals within the Sixth Circuit, is a substantial increase in the risk of penalty or liability for EMTALA violations.

The current national debate over health care policy spotlights the financial stress on America's health care system and the plight of those struggling to afford the ever-increasing cost of health care. EMTALA ensures that emergency medical care is available to those who are uninsured, underinsured, or otherwise without financial means to pay for the emergency care that they need. The Sixth Circuit's expansion of EMTALA responsibility beyond the emergency room, and to possibly indefinite hospitalization and treatment, compounds the financial stress on Michigan's community hospitals. Consequently, MHA and its constituents have a substantial stake in the outcome of this case.

SUMMARY OF ARGUMENT

Congress enacted EMTALA in 1986 in response to concerns that hospital emergency rooms were refusing to treat patients with emergency conditions if the patients did not have medical insurance. The statute requires Medicare participating hospitals to provide an "appropriate medical screening examination" to any individual who comes to the emergency department, to determine whether an "emergency medical condition" exists. If the patient has such a condition, the hospital must then either provide care to stabilize that condition, or transfer the individual to another medical facility if medically indicated. Thus, the statute requires emergency department admission and treatment to assure "no material deterioration of the [emergency medical] condition." The hospital must

provide these services regardless of the patient's lack of insurance or other inability to pay for the services.

The Fourth and Ninth Circuits, and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services, have all interpreted EMTALA as imposing these obligations on emergency departments. All have held that EMTALA obligations end there and do not continue when the hospital has, in good faith, admitted the individual to the hospital for inpatient treatment. The decisions of those Circuits, and of the CMS resulting in its promulgated regulation, are all correct.

By contrast, the Sixth Circuit has, in this case, held that EMTALA obligations extend indefinitely even to those patients who have been admitted for inpatient care. Consequently, the circumstances in this case involving a patient who was admitted from the emergency room to the hospital for six days of inpatient care, have been held by the Sixth Circuit to support a claim for EMTALA violation—failure to stabilize. The Sixth Circuit's interpretation of the EMTALA statute is not compelled by its language and expands EMTALA rights and obligations well beyond the Congressional intent. Moreover, the decisions of the other Circuits that are directly contrary to this one are correct as a matter of law, and the Sixth Circuit has erred by holding otherwise.

Further, the Sixth Circuit should have honored the well-considered and duly promulgated CMS regulation which is in line with the other Circuits and directly contrary to the Sixth Circuit's decision.

The Sixth Circuit's decision materially and substantially affects Michigan's community hospitals as represented here by the MHA. This decision has significant adverse financial implications for Michigan's community hospitals which are already suffering from the impact of uncompensated care for the uninsured. Michigan's community hospitals and other health care providers within the membership of the MHA have a great need for the Court to grant this Petition.

ARGUMENT

The Sixth Circuit's Expansion of EMTALA Rights and Obligations to Individuals Admitted to the Hospital for Inpatient Treatment is a Matter of Great Concern to Michigan's Community Hospitals and Merits Review by this Court.

Judge Richard Griffin's dissent in this case states, succinctly, why this Court must grant the Petition and review the majority's decision. Judge Griffin criticizes the majority for following the earlier suggestion in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), that a hospital's EMTALA obligations do not end at the emergency room, but that they continue with application to individuals who are afforded inpatient treatment. As a consequence of this decision, those obligations, and potential liability and penalty for breach, continue indefinitely. By this decision, EMTALA obligations might continue even though the individual has been admitted for years; for example, in the case of an individual who has presented with psychological conditions.

Other Circuits, the Ninth and the Fourth, have rejected this interpretation of the EMTALA statute, holding that the language of the statute does not compel its application beyond the emergency room to patients admitted to the hospital for inpatient treatment. Judge Griffin's dissent summarizes the most obvious reason why this Court must review and decide this issue:

> By remaining loyal to the errant obiter dictum contained in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), the majority has perpetuated a serious conflict between our Circuit and the Ninth Circuit, *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), the Fourth Circuit, *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349 (4th Cir. 1996), the Federal Regulations, 42 C.F.R. § 489.24(D)(2)(i), and the vast majority of lower court decisions. See generally *Preston v. Meriter Hosp., Inc.*, 747 N.W.2d 173 (Wisc. Ct. of App. 2008), *petition for review denied*, 749 N.W.2d 662 (Wisc. 2008), and cases cited therein.

Judge Griffin went on to say:

> Our panel decision misconstrues EMTALA, making it a general federal medical malpractice statute, rather than an act limited to emergency room screening and stabilization. *Bryan*, 95 F.3d at 351.

The MHA fully concurs in Judge Griffin's dissenting rationale and the many authorities, including the Fourth and Ninth Circuits, and the

regulations promulgated by the Centers for Medicare and Medicaid Services, all of which are contrary to the majority's decision in this case. There is little more for the MHA to say in support of those arguments. The greater reason for MHA's support of Providence Hospital's Petition is for the Court to know the great importance of the issue for the MHA and its constituents.

The MHA does not question here, at all, the wisdom or ethical imperative for the EMTALA legislation. In fact, the purpose for which EMTALA was adopted by Congress is fully consistent with the mission of MHA and its constituent groups—to serve as the health care safety net for all of Michigan's residents.

But there is great cost associated with these obligations, and it is borne by Michigan's hospitals and the health care system in general. The MHA's community benefits survey of Michigan's nonprofit hospitals in 2008 found that they offered $2.6 billion in community benefit in 2007. Although that number includes health education and outreach, it also includes free services, charity care, and unpaid care.

Those who have studied EMTALA in operation over the last two decades have universally noted the stresses that it has placed on the health care system, both in terms of dollars and in terms of the manpower and hospital capacity. Individuals are coming to emergency departments in ever-increasing numbers, without medical insurance or other financial means to

pay. According to the American College of Emergency Physicians[2]:

> Hospitals and physicians shoulder the financial burden for the uninsured by incurring billions of dollars in bad debt or "uncompensated care" each year. Fifty-five percent of emergency care goes uncompensated, according to the Centers for Medicare and Medicaid Services. The amount of uncompensated care delivered by nonfederal community hospitals grew from $6.1 billion in 1983 to $40.7 billion in 2004, according to a 2004 report from the Kaiser Commission on Medicaid and the Uninsured.
>
> In the past, hospitals shifted uncompensated care costs to insured patients to make up the difference. However, cost shifting no longer is a viable option because managed care and other health plans have instituted strict price controls, leaving little margin to shift costs. More than one-third of emergency physicians lose an average of $138,300 each year from EMTALA-related bad debt, according to a May 2003 American Medical Association study. Emergency physicians and other specialists combined lost $4.2 billion in revenue in 2001 providing care mandated by EMTALA.
>
> With projections that health care costs will double and the number of uninsured will increase to $53 million by the year 2007, the

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[2] The Uninsured: Access to Medical Care, available at *www.acep.org/patients.aspx?id=25932.*

> nation is faced with how it will continue to provide care for all Americans, not just the disadvantaged. Emergency departments provide an essential community service, similar to fire departments, police departments, and public utilities. The nation cannot afford to allow the emergency care system to collapse because of a lack of funding. It is too high a price to pay in terms of public health effects and human suffering.

Several years ago Congress appropriated some money to address uncompensated care. It appropriated $1 billion over fiscal years 2005-2008 to reimburse hospitals for medical care provided to undocumented aliens. Two-thirds of the appropriated money is allotted to the states based upon the number of undocumented aliens in each state. The remaining one-third is allotted to the six states with the highest numbers of apprehended undocumented aliens. P.L. 108-173, Title X, Subtitle B, § 1011, 117 stat. 2432 (2003). The money available to hospitals through this appropriation is a very small portion of the unfunded cost of EMTALA-related emergency care.

In this case, the Sixth Circuit has interpreted EMTALA erroneously resulting in an expansion of EMTALA rights and obligations with the attendant expansion of potential liability and penalty for hospitals alleged to violate the EMTALA requirements. In other words, the result of the Sixth Circuit's decision is additional financial stress on Michigan's community hospitals. They are already struggling with the financial and facilities costs of providing EMTALA-mandated care.

Individuals who are admitted to hospitals for inpatient treatment already have, without regard to EMTALA, various safeguards to ensure proper care. Hospitals and other health care providers, apart from EMTALA, face potential liability for breaches of those duties associated with those safeguards, with regard to inpatient treatment. If those individuals (admitted inpatients) may also claim statutory damages for EMTALA violations, and where hospitals face the potential of other penalties under EMTALA, then EMTALA is adding significant potential cost for these hospitals and the nation's health care system. This is a matter of grave concern to the MHA and its constituent members. Consequently, the MHA asks that this Court recognize the great importance of this issue for the MHA, its constituents, and the health care system in general, and that the Court grant the Providence Hospital's Petition.

The current national health care debate has focused the attention of all, politicians and the public alike, on questions regarding health care in the face of ever escalating costs, the plight of those who are either unable to find or afford health care insurance, and financial and facility stresses on the nation's health care system which result from underfunding. The Sixth Circuit's expansion of potential EMTALA liability in this case, as it will apply to hospitals throughout the Sixth Circuit, is significant with regard to all of these concerns. Consequently, the MHA respectfully submits that this case is a very significant one for this Court's attention, and that the Petition should be granted.

CONCLUSION

This Court should grant the Petition for Writ of Certiorari.

The Michigan Health & Hospital Association urges this Court to grant the Petition for Writ of Certiorari to review the very important issue of the scope of the EMTALA statute, to give proper effect to the intent of Congress. The Sixth Circuit Court of Appeals, in its majority decision, has erroneously applied EMTALA rights and obligations well beyond the language and intent of Congress, thereby creating additional financial and facilities stress on Michigan's community hospitals.

Respectfully submitted,

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